

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-034666
STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Register District No. 1002 Primary Registration District No. 1002 Registrar's No. 4700

VS 300
Rev. 4/59

1
2 3818
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4 0
5 1
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7 0
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DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

Harry Statland

1. PLACE OF DEATH a. COUNTY <u>JACKSON</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> COUNTY <u>JACKSON</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>KANSAS CITY</u>		c. CITY OR TOWN <u>KANSAS CITY</u>	
Length of stay in 1b <u>45 years.</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>5914 The Paseo</u>		d. STREET ADDRESS (If outside, give location) <u>5914 The Paseo</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>J.</u> Last <u>CARTER</u>		4. DATE OF DEATH Month <u>September</u> Day <u>12</u> Year <u>62</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>CAUC.</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 5, 1897</u>
9. AGE (last birthday) <u>65</u>		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
11. IF UNDER 24 HR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PAINTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Interior Decorating</u>	
11. BIRTHPLACE (City and state or country) <u>Sedalia Missouri</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13a. FATHER'S NAME <u>WALTER SCOTT CARTER</u>		13b. MOTHER'S MAIDEN NAME <u>Eva L. Hedges</u>	
14. NAME OF HUSBAND OR WIFE <u>ANN CARTER</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>	
16. SOCIAL SECURITY NO. <u>W.W.L.</u>		17. INFORMANT <u>ANN CARTER</u>	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>		INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>arteriosclerotic heart disease</u>		years <u>0</u>	
DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m.	Month, Day, Year _____		
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from <u>6-30-62</u> to <u>death</u> and last saw her/him live on <u>8-22-62</u>		Death occurred at _____ m on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Degree or title) <u>Harry Statland MD</u>		22b. ADDRESS <u>751 E. 63 ST</u>	
22c. DATE SIGNED <u>9-14-62</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>	23b. DATE <u>Sept. 15, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bayless Cemetery</u>	
23d. LOCATION (City, town, or county) (State) <u>Bayless, ILLINOIS</u>			
24. FUNERAL DIRECTOR <u>Muehlebach</u>		25. DATE RECD. BY LOCAL REG. <u>9-14-62</u>	
ADDRESS <u>6800 TROST</u>		26. REGISTRAR'S SIGNATURE <u>Ruth Long</u>	

Dr Statman
751 E 63rd

De 3.6000

call his office
noon Friday.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed *C. D. Nelson*

Licensed Embalmer No. *4421*

P. O. Address *K.C. Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.